

Community Consolidated School District 181

115 West 55th Street • Clarendon Hills, IL 60514

Phone: (630) 861-4900 • FAX: (630) 887-1079

PHYSICIAN'S STATEMENT OF GOOD HEALTH

Name: _____ **Phone:** _____

Address: _____

Male _____ **Female** _____ **Birth Date:** _____

Section 24-5 of the School Code states in part – “School boards shall require of new employees evidence of physical fitness to perform duties --- presentation to the board and cost of such examination shall rest with the employee.”

Please have your physician complete this form and attach the physical examination form provided from his/her practice.

PHYSICAL EXAMINATION

I have determined that the above named applicant is able to perform the essential functions and duties as determined by the position for which he/she has applied without reasonable accommodations, and that he/she is free of communicable diseases.

Date: _____ / _____ / _____

Physician Name: _____

Signature, M.D.: _____

Address : _____

Physician Office Telephone: _____

Please return to: Human Resources Department (address above)